Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #1 I am satisfied with quality of care from my doctors (Ridgeview)	**69.70** Performance (2025/26)	**73** Target (2025/26)	**63.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Communicate role of Medical Director and Physicians and give opportunity for feedback

Process measure

- 1) # of meetings with Councils where Medical Director attended 2) # of suggestions provided by councils 3) # of CQI meetings where action items were discussed with Medical Director

Target for process measure

- 1) Medical Director will attend Family Council by September 30, 2025 2) Medical Director will attend Resident Council by September 30, 2025 3) Action items and plan will be discussed at CQI committee with Medical Director by October 31, 2025.

Lessons Learned

The Medical Director attended resident council and quality meetings. No concerns were raised by residents; however, residents expressed a desire for more frequent medical presence.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Tracking of in person resident visits to ensure everyone has a visit

Process measure

- 1) # residents per physician 2) # of residents who had in person visit during quarter

Target for process measure

- 1) List will be developed by physician for tracking by April 30, 2025 2) Each resident will have an in person visit with physician / NP at minimum 1 per quarter by December 31, 2025

Lessons Learned

Tracking all physician and nurse practitioner visits was challenging due to the absence of a standardized tracking process. At times, physicians or nurse practitioners rounded independently.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Improve visibility of doctors in the home with residents and families.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Order Extendicare name tags all for doctors and
Utilize a communication board for families /residents so they are aware of when physician is going to be onsite.

Comment

The target was not met, as the Medical Director and attending physicians did not consistently meet with residents during rounds. Residents expressed a desire for regular medical visits and physicians are expected to meet with residents when rounding.

Indicator #3

I am satisfied with the quality of cleaning in the residents room

(Ridgeview)

Last Year		This Year		
86.00	**88**	**45.50**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Training for staff on proper use of microfiber cleaning systems

Process measure

- 1) # of education sessions held for housekeeping on use of microfiber cleaning systems 2) # of housekeeping staff that attended the education 3) # of follow up audits completed per month

Target for process measure

- 1) Education session for housekeeping staff will be held by September 30, 2025 2) 100% of housekeeping staff will have completed education by September 30, 2025 3) There will be a 20% improvement in follow up audits for cleaning.

Lessons Learned

All housekeeping staff received training on the proper use of microfiber cleaning systems.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Review deep clean schedules for resident rooms

Process measure

- 1) # of times deep clean schedule reviewed 2) # of resident rooms who have had deep cleaning completed 3) # of audits completed of resident rooms to ensure deep cleaned.

Target for process measure

- 1) Support Services manager will review deep clean schedule by September 30, 2025 2) 20 % of resident rooms will have been deep cleaned by September 30, 2025, with 100% being completed by December 31, 2025 3) There will be a enter 10% improvement in completion of deep clean audits by December 31, 2025

Lessons Learned

Deep cleans were completed for all rooms. Audits were conducted by the ESM.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Review of high touch areas and dusting schedule.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Environmental Services Manager to review high touch and dusting schedule and update as needed. Track resident rooms as per schedule to ensure all residents have areas cleaned. Follow up audits to be completed to ensure completion.

Comment

The target was not met as a result of decreased family satisfaction survey scores and staff turnover. Corrective actions include replacing the original carpet with vinyl flooring, retraining new hires, and ongoing audits to ensure housekeeping policy compliance.

Indicator #4

I feel my goals and wishes are heard and considered in my care

(Ridgeview)

Last Year		This Year		
72.50	**75**	**96.30**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Quarterly plan of care reviews will be completed with each resident input

Process measure

- 1) # of plan of care meetings held with resident present 2) # of resident plans of care updated to reflect goals and wishes after discussion

Target for process measure

- 1) Plan of care meetings will be held with resident in attendance by September 30, 2025 2) 10 % of plans of care will be updated by September 30, 2025

Lessons Learned

When the plan of care is reviewed, staff meet with the resident, if able, to discuss goals and wishes, and the plan of care is updated based on those discussions. This was well received by residents.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Training for staff on person centered care

Process measure

- # of staff who attended sessions # of sessions provided

Target for process measure

- 1) Education session on person centered care will be completed by Sept 30, 2025 2) By Sept 30, 2025 50% of staff will have completed the education.

Lessons Learned

Education sessions on person-centered care were completed and positively received by staff. The sessions were facilitated by trained GPA coaches.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve communication

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Education sessions on person-centered care highlighted respecting residents wishes and improved communication among staff to ensure residents wishes are documented and plan of care updated.

Comment

The target was met and exceeded. Residents reported appreciation for being included in their care planning, attended care conferences, and felt comfortable communicating with staff when they felt changes were necessary.

	Last Year		This Year		
Indicator #2 I am satisfied with the quality of care from my physiotherapist (Ridgeview)	**66.70** Performance (2025/26)	**69** Target (2025/26)	**75.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Highlight physiotherapist in monthly newsletter to increase awareness

Process measure

- 1) # of newsletters where physiotherapist was highlighted 2) # of newsletters sent to residents and families 3) Newsletter posted on bulletin board.

Target for process measure

- 1) Monthly newsletter will highlight physiotherapist and role by July 31, 2025 2) Newsletters will be sent to residents and families by July 31, 2025 3) Newsletter will be posted on bulletin board by July 31, 2025

Lessons Learned

Effective communication was observed, with families reaching out to the physiotherapist and providing positive feedback.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve visibility of physiotherapist in home with residents and families

Process measure

- 1) Review and feedback from Resident and Family Council 2) number of times PT met with Family and Resident councils 3) number of times action plan update given at CQI meeting

Target for process measure

- 1) PT will attend Family Council by November 30, 2025 2) PT will attend Resident Council by November 30, 2025 3) Action items and plan will be discussed at CQI committee with PT by November 30

Lessons Learned

Improved interaction between the physiotherapist, residents, and families was observed.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Increase rehab treatments through collaboration with recreation (functional fitness/abilities).

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Determine staffing to support.
Develop action plan based on need/available time.
Review and determine therapy programs.
Implement treatments per care plan.

Comment

The target was met, with the physiotherapist demonstrating increased visibility in home areas and improved interaction with residents and families.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #5 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Ridgeview)	**11.50** Performance (2025/26)	**11.40** Target (2025/26)	**14.44** Performance (2026/27)	**-25.57%** Percentage Improvement (2026/27)	**14** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement /Reassess Falling Star program and reeducate staff on program

Process measure

- 1) # of education sessions provided to PSW and Registered staff 2) # of audits completed on Falling star program monthly 3) # of audits on Falling star program with no deficiencies

Target for process measure

- 1) Education sessions for PSW and Registered staff will be completed by August 29, 2025, 2) Audits on Falling star program will begin by September 15, 2025

Lessons Learned

The ADOC and Fall Lead delivered education sessions on the Falling Star Program to all PSWs and registered staff across all units and shifts. Audits were conducted, and progress was monitored to ensure effective implementation.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement 4 P's rounding

Process measure

- 1) # of staff educated on the 4P's process 2) # of 4P cards provided 3) Resident council and family council informed of process

Target for process measure

- 1) 100% of front-line staff will be educated on 4P process by August 29, 2025 2) 4P cards will be distributed to staff by August 29, 2025, 3) Resident council and Family council will be informed of process by March 7, 2025.

Lessons Learned

Staff were educated on the 4P's process, 4P's handouts were provided as reminders, and the Resident Council and Family Council were informed about the 4P's process.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Re-education on Safe Resident Handling Policy with Staff

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Education on Safe Resident Handling program
Random auditing of safe resident handling practices in the home
Identify deficiencies and develop plan of action for gaps

Comment

A comprehensive range of fall prevention interventions was implemented and evaluated throughout the year. Weekly falls meetings were maintained, staffing levels were adjusted during high-risk peak times, job routines were revised, and staggered breaks were implemented on evening shifts. Registered staff assumed responsibility for resident rounding, and all staff were reinforced on the completion of hourly 4P rounding. Additional staffing resources were allocated to units with higher-risk fallers, and high-risk residents were identified in back meeting rooms to support staff awareness. Alarm audits were increased across all shifts, and unnecessary alarms were discontinued to reduce alarm fatigue. Ongoing staff engagement was supported through multiple huddles and unit-based falls meetings to identify and implement new prevention strategies. Falls Month activities were conducted to reinforce education and engagement. Referrals were initiated to the Falls Lead for residents experiencing acute illness or changes in medication to support timely risk assessment and intervention.

Indicator #6	Last Year		This Year		
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Ridgeview)	**15.11**	**15**	**9.46**	**37.39%**	**9.40**
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement Extendicare's Antipsychotic Reduction Program which includes using the Antipsychotic Decision Support Tool (AP-DST).

Process measure

- 1.) home team established 2). Schedule regular meetings for antipsychotic review 3). Attendance to the Quality Labs 4.) Percentage of residents with an action plan inputted."

Target for process measure

- 1). Home team will be established by April 30, 2025 2). Education and training completed by June 30, 2025 for 100% of required staff 3). Antipsychotic review meetings are occurring every week by July 1, 2025 4). Residents triggering the Antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission with 100% compliance by Sept 30, 2025

Lessons Learned

An Antipsychotic (AP) Home Team was established with regularly scheduled meetings to review antipsychotic use. The team attended Quality Labs, and the percentage of residents with an antipsychotic action plan entered and monitored was tracked.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.

Process measure

- 1) # of medication reviews completed monthly 2) # of diagnosis that were appropriate for antipsychotic medication use 3) # of alternatives implemented

Target for process measure

- 1) 75% of all residents will have medication and diagnosis review completed to validate usage by July 30 ,2025 2) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by Aug 30, 2025.

Lessons Learned

Physicians completed medication reviews for residents prescribed antipsychotic medications with pharmacy support. Diagnoses and clinical rationale for antipsychotic use were reviewed, and alternative treatment options were considered where appropriate.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Documentation: Collaborate with Registered Staff, Physician / Nurse Practitioner to ensure all residents using anti-psychotic medications have a documented indication by diagnosis and/or rationale for symptom-management identified in the resident's diagnosis list and care plan (i.e., monthly care plan reviews).

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Complete medication reviews for residents prescribed antipsychotic medications.
Consider non-pharmacological approaches as appropriate to reduce anti-psychotic use and document assessment findings and management planning.

Comment

The target was met. Utilizing a multidisciplinary approach was key to reducing antipsychotic medication use. The Home Team collaborated closely with the BSO team, psychogeriatric specialists, pharmacy, staff, and residents. It was this combined, team-based effort that contributed to the successful outcome.

Safety | Safe | Custom Indicator

Indicator #8

Restraints: Percentage of residents who were physically restrained (daily)

(Ridgeview)

Last Year		This Year		
0.58	**0.50**	**0.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement per unit tracking for all restraints to better analyze and review trends on each unit.

Process measure

- 1). # of unit tracking tools implemented by unit 2.) # of tracking tools completed monthly 3.) # of analysis completed by restraint team on results.

Target for process measure

- 1). Tracking tool implemented on each unit by September 30, 2025. 2.) 100% of tracking tools will be completed accurately by September 30, 2025. 3). Process for analysis of tracking tool results by restraint team will be 100% in place by September 30, 2025

Lessons Learned

A unit-level tracking tool was implemented to collect data and better analyze and monitor trends related to restraints. Completed tracking tools are collected monthly, and the Restraint Team/Quality Team analyzes the results to guide improvement strategies.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Provide information to families and residents on Least Restraint.

Process measure

- 1.) # of admission packages with Restraint brochure included. 2.) # of meetings with Resident and Family council to discuss Least Restraint and Risks.

Target for process measure

- 1). 100% of admission packages will have Restraint brochure included for new admissions by September 30, 2025 2). Meetings with Resident and Family councils will be attended to discuss Restraints by September 30, 2025

Lessons Learned

Restraint brochures were included in admission packages for new residents. Education on the Least Restraint approach and associated risks was provided to both the Resident and Family Councils.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Admission coordinator/designate will review each application received for restraints prior to move-in

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Admission coordinator reviews and flags each application received for restraints, Information is sent to LHIN to indicate that the home is least restraint and alternative will be trialed upon move-in

Comment

The target was met, and the goal is to maintain current performance through ongoing education for families and by reviewing the Least Restraint policy with new admissions.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #7 Pressure ulcers: Percentage of residents who had a pressure ulcer that recently got worse (Ridgeview)	**1.35** Performance (2025/26)	**1.30** Target (2025/26)	**1.50** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Mandatory education for all Registered staff on correct staging of Pressure ulcers

Process measure

- 1) # of communications to Registered staff mandatory requirement to complete education. 2) # of Registered staff who have completed online modules on wound staging on a monthly basis. 3) # of audits of completion rates completed by DOC/designate and follow up as required.

Target for process measure

- 1) Communication on mandatory requirement will be completed by June 30, 2025 2) 100% of Registered staff will have completed education on correct wound staging by September 30, 2025 3) Audits of completion rates will be completed monthly with required follow up will occur by 1st week of each month and process is to be in place by September 30, 2025

Lessons Learned

Registered staff were informed of the requirement to complete education on wound staging. Staff were expected to complete online modules by the end of the third quarter, and the DOC/designate monitored completion rates to ensure compliance.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement per unit tracking for all pressure ulcers to measure status and trends of pressure ulcers in the home.

Process measure

- 1) # of education sessions held for Registered staff on tracking tools 2) # of tracking tools completed monthly 3) # of tracking tools that were reviewed on a monthly basis for trends "

Target for process measure

- 1) 100% of Registered staff will have attended education sessions on tracking tool by June 30, 2025 2) Tracking tools will be correctly completed on a monthly basis by September 30, 2025 with 75% improvement 3) Process for review, analysis and follow up of trends from tools will be 100% in place by September 30, 2025

Lessons Learned

Education was provided to staff on the use of the tracking tool on each unit. The tool was implemented on all units and shifts, and the Wound Care Lead collected the completed tools to analyze trends and identify opportunities for improvement.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Education on Product Selection and wound care.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Education sessions set up for all registered staff on products on wound care protocol, sessions to be arranged for all shifts, Audits to be completed by wound care lead of the home for correct usage of products.

Comment

Although the target was not met, the score remained below the benchmark. Education was well received by staff. It was noted that some residents returned from hospitalization with pressure ulcers, which impacted overall outcomes.